The Patient Centered Medical Home

Health Reform Has Begun in the Kansas!

Michael Kennedy, MD, FAAFP
Chair of the Board of Directors, KAFP
Associate Dean of Rural Health Education, KUMC
Assistant Professor of Family Medicine, KUMC
Physician Liaison to the KHPA Medical Home Project

Agenda

- Outline the need for health care reform in U.S.
- Describe the rationale for why there is a need for fundamental change in the delivery of primary care
- Briefly describe the Patient Centered Medical Home (PCMH) in an ambulatory model of practice.
- Describe current Kansas Activities for PCMH transformation.
- Where does HIT operate in a medical home environment.

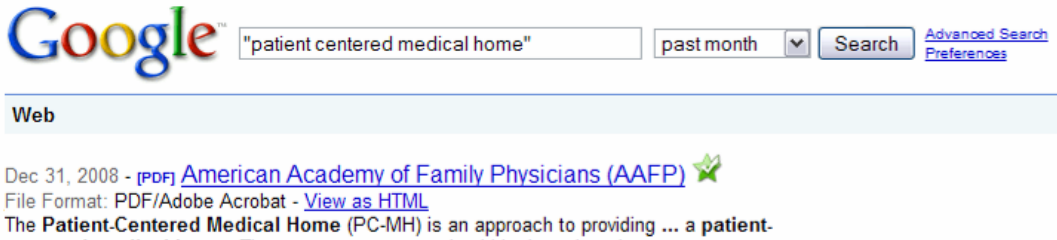
What is it, AGAIN?

- Definition in Kansas SB 81-2008

…"medical home" means a health care delivery model in which a patient establishes an ongoing relationship with a physician or other personal care provider in a physician-directed team, to provide comprehensive, accessible and continuous evidence-based primary and preventive care, and to coordinate the patient's health care needs across the health care system in order to improve quality and health outcomes in a cost effective manner.

http://www.kslegislature.org/bills/2008/81.pdf

HOT ITEM



Dec 31, 2008 - [PDF] American Academy of Family Physicians (AAFP)
File Format: PDF/Adobe Acrobat - View as HTML
The **Patient-Centered Medical Home** (PC-MH) is an approach to providing ... a **patient-centered medical home**. The payment structure should be based on the ...
www.medicalhomeinfo.org/joint%20Statement.pdf - Similar pages

Jan 9, 2009 - [DOC] Jennifer Lail MD has practiced clinical pediatrics at Chapel Hill ...
File Format: Microsoft Word - View as HTML
Currently, she is serving on the National Committee for Quality Assurance (NCQA) Advisory Panel for the **Patient-Centered Medical Home** Expansion. ...
www.medicalhomeinfo.org/training/Lail%20Brief%20Bio.doc - Similar pages

Jan 13, 2009 - ACP Internist: The **patient-centered medical home**--at home
The **patient-centered medical home**--at home. Sometimes medicine is cyclical. Leeches went thoroughly out of style, and then it turned out that bleeding ...
blogs.acponline.org/acpinternist/2009/01/**patient-centered-medical-home**-at-home.html - 22k - Cached - Similar pages

Dec 31, 2008 - How not to sell the **patient centered medical home** - KevinMD.com
How not to sell the **patient centered medical home**. The medical home model is often said to be the savior of primary care. ...
www.kevinmd.com/blog/2008/12/how-not-to-sell-patient-centered.html - 27k - Cached - Similar pages

Jan 14, 2009 - Readiness for the **Patient-Centered Medical Home**: Structural ...
Interest in improving quality of care has driven efforts to develop the **patient- centered medical home** (PCMH) model. However, readiness to implement the ...
www.commonwealthfund.org/publications/publications_show.htm?doc_id=784457 - 28k - Cached - Similar pages

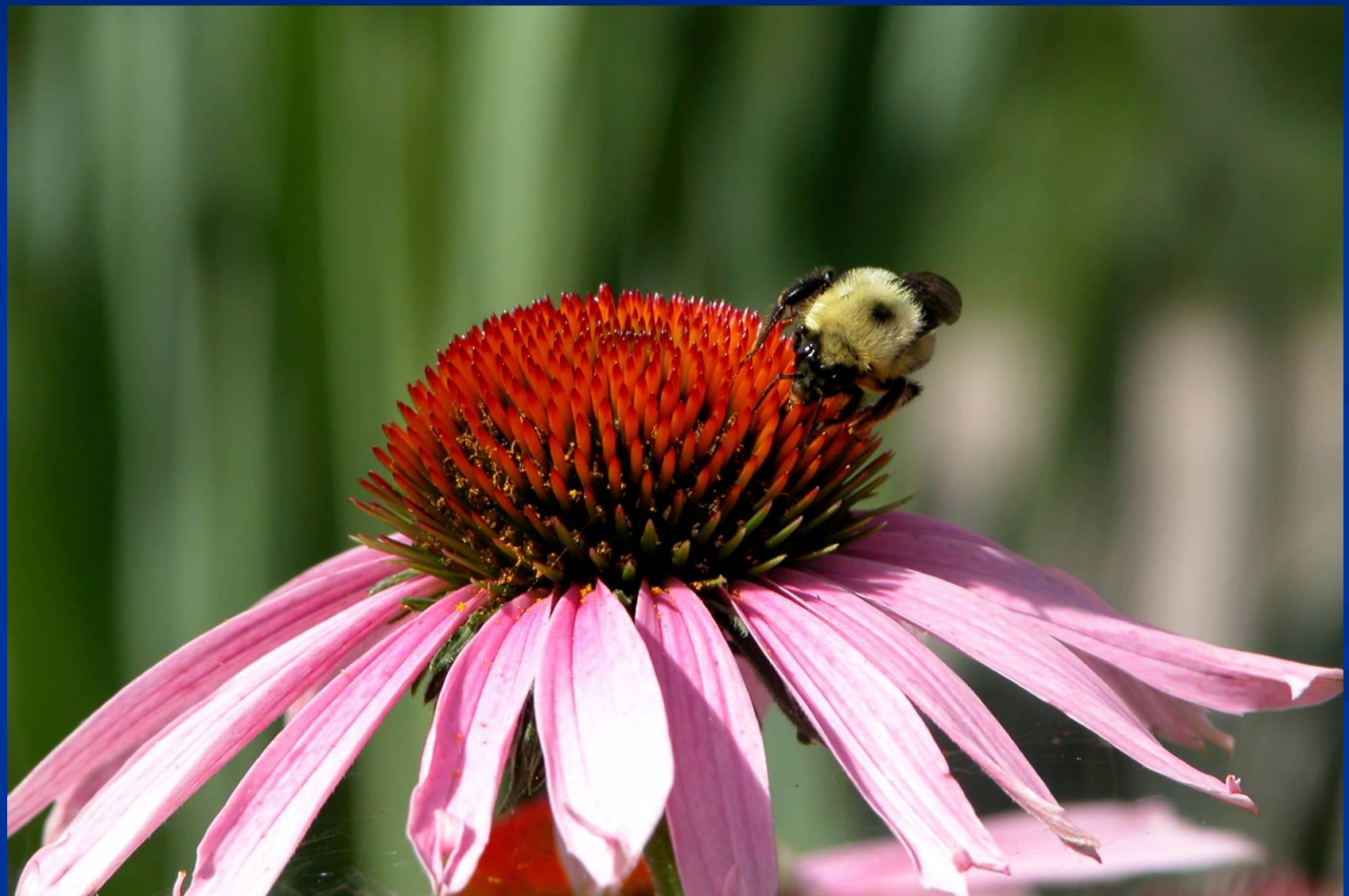
Jan 14, 2009 - [PDF] Readiness for the **Patient-Centered Medical Home**: Structural ...
File Format: PDF/Adobe Acrobat - View as HTML
patient-centered medical home (PCMH) model. However, readiness. to implement the reforms necessary for establishing a PCMH— ...
www.commonwealthfund.org/usr_doc/Friedberg_readinesspatient-centeredmedhome_1224_itl.pdf?section=4039 - Similar pages

Dec 22, 2008 - The **Patient-centered Medical Home** Movement
This commentary offers a review of family medicine's internal strengths and weakness related to the PCMH, including the external opportunities and threats.
www.medscape.com/viewarticle/585210 - Similar pages
by A Agenda

Medical Home
#1 Technology for Medica
Used Statewide in North
www.mddatacor.com

Medical Home Syste
Collect and analyze clinic
patient medical home init
www.cieloMEDsolutions.

Careful Health Care Reform to Avoid Getting Stung!!!!



Why Now?

- It's time.
  - Today, the U.S. faces the reality that its health care system produces poorer health outcomes at a much greater cost than systems of other industrialized nations that are built on a solid primary care foundation. Legislators, employers, and patients are looking for a transformational change in health care which includes better coordination, access, value and quality. Physicians, payers (insurance and business) and patients are aligned behind the concept of the Patient Centered Medical Home because it offers a sensible alternative to a health care system that is costly, inefficient, and simply not sustainable.

Health Care in Crisis

- The system is flawed and failing.
  - Healthcare costs are skyrocketing
  - 1/2 of all bankruptcies and 1/2 of all home foreclosures are related to medical costs
  - Medical tourism: Thousands of people leave the United States because the quality and the cost is better in other countries
  - In the World we are:
    - 29th in infant mortality
    - 24th in overall women's health
    - 31st in life expectancy
    - 37th overall in outcomes

3 Main Problems

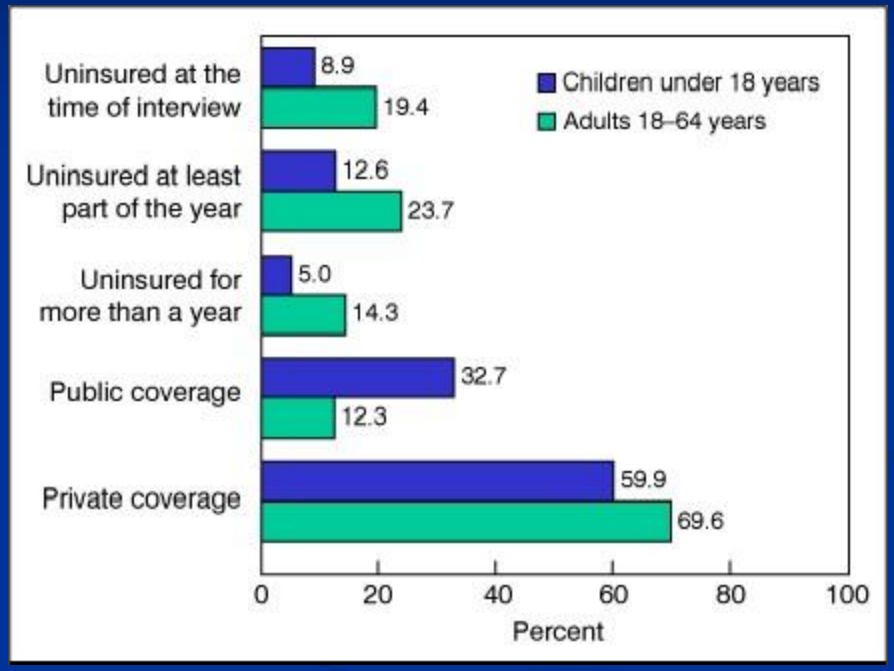
- Cost
- Access
- Quality

Cost

- We pay for our healthcare in one of three ways, but all of us pay in all three ways
  - Taxes
  - Premiums
  - Out of pocket expense.
- $7,500 for every man, woman and child in the country
  - 16% of our GDP
  - Over 40% more than the second most expensive country in the world.
  - General motors spends more on healthcare than they do on steel.
  - Starbucks spends more on healthcare than they do on coffee.
- That $7500 is expected to double by the year 2015 if we do nothing.

Access

- 47 million people have no health insurance
- At 7.5% unemployment
  - 2.5 million additional uninsured in the country
- 40% of the people in this country are under insured
- Don't have mental health parity
- Poor long term care
- Poor dental care
- Rural areas have special challenges



From the CDC 6/2008

Quality

- Related in part to cost
- Related in part to access
- The congressional budget office has estimated
  - Of the 2+ trillion dollars we spend on healthcare, 700 billion could be unnecessary
    - That's about a third may be unnecessary.
    - Part of the reason…we are still driving this huge part of our economy by paper
    - That paperwork is costing
      - 15-25% of all healthcare costs are now attributed to the administration of our system

Primary Care Physician Practice Issues

- Paperwork burden
- Cost of education for medical professionals
- Increased value placed on time with family
  - Training work-hour limitations
  - Work hour self limitations
  - Gender influence
- Medical malpractice
- Frustration getting needed services for patients
  - Prior authorizations
  - Letters of medical necessity
  - Covered vs non-covered services
- Relatively low payment

Job Satisfaction

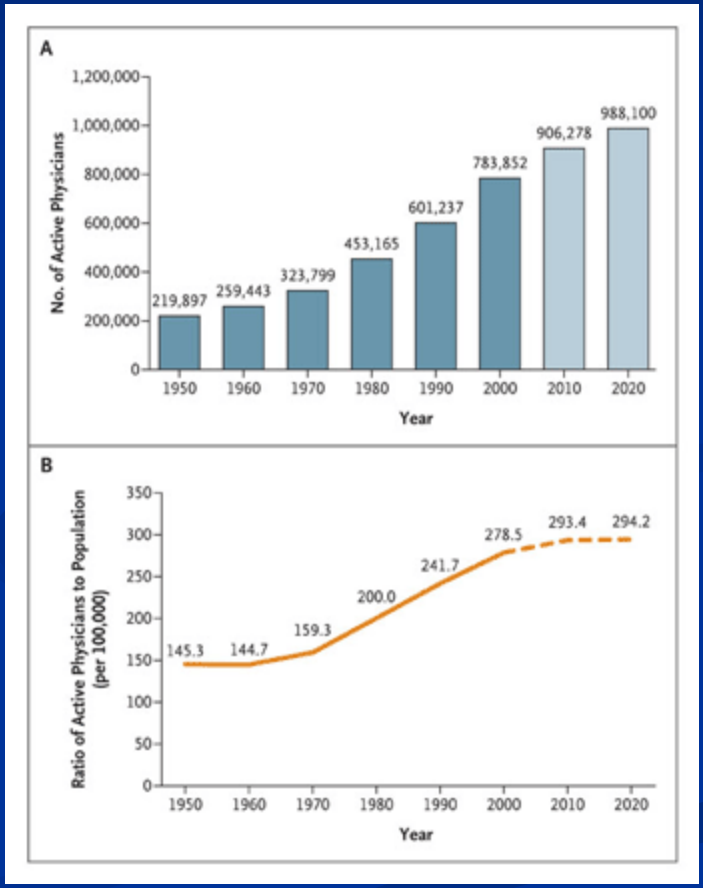
Table 1. Attitudes of Physicians under the Age of 50 Years Regarding Factors Affecting Satisfaction with Their Career, According to Sex.*

Factor	"Very Important"	
	Men	Women
	percent	
Time for family and personal life	66	82
Flexible scheduling	26	54
No call or limited on call	25	44
Minimal responsibility for practice management	10	18
Practice income	43	33
Long-term income potential	45	36
Opportunity to advance professionally	29	27

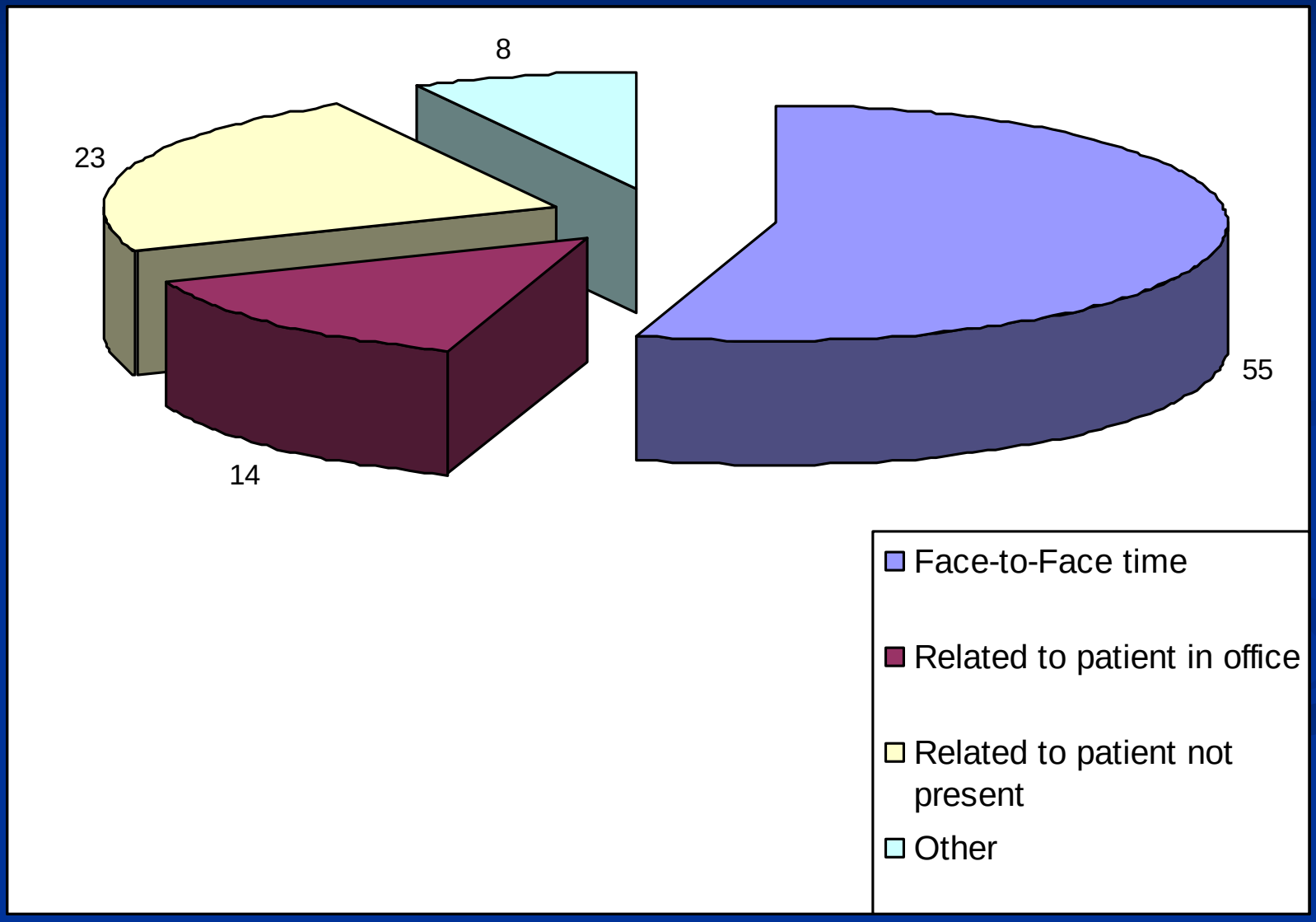
* Data are from the Association of American Medical Colleges 2006 Survey of Physicians under 50.

Current Trend in Workforce

- Even though the number of physicians are increasing, the ratio to the population is predicted to peak in 2016 and then begin to fall.

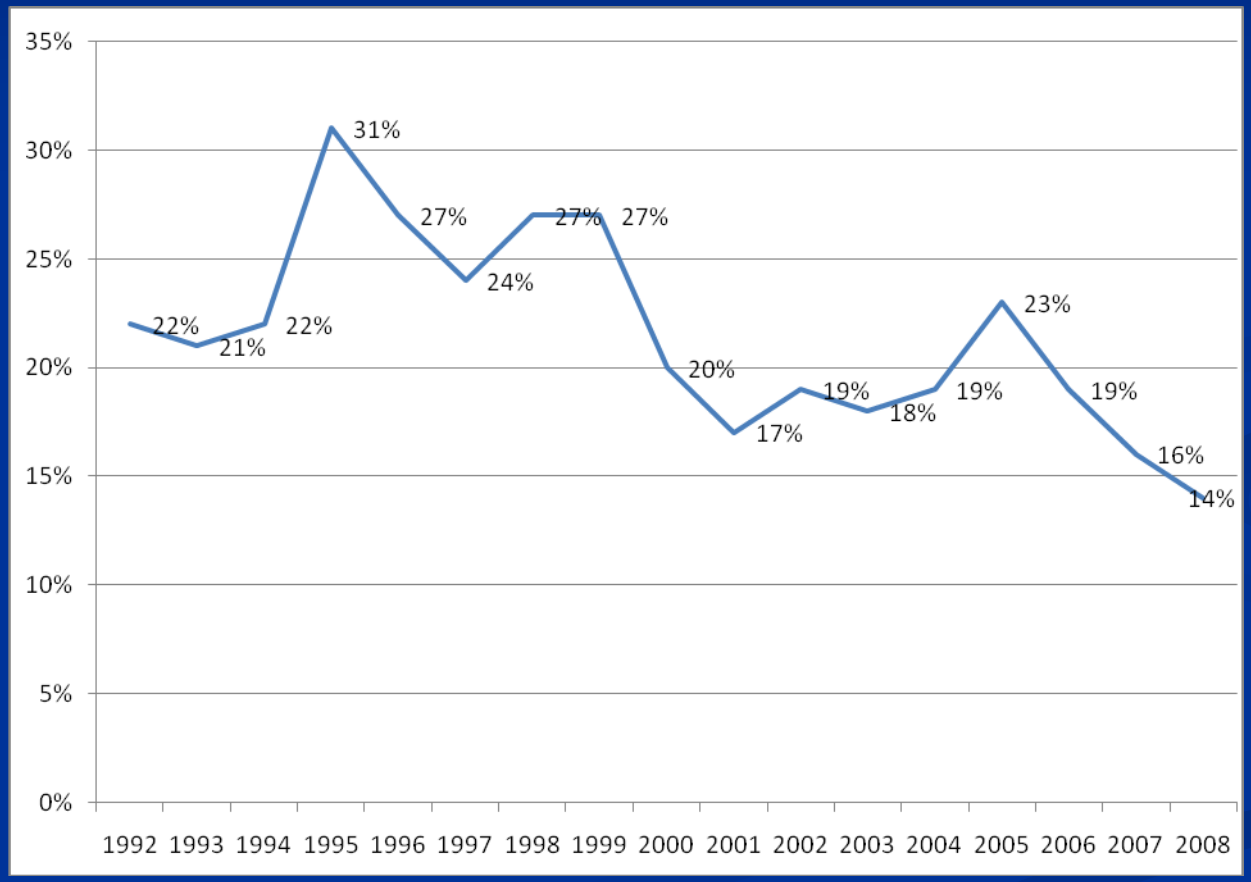


Time Breakdown for Ambulatory Primary Care



Interest is low for FM choice

Percent of Students Choosing Family Medicine Residency at KUMC



Unpublished data from the Kansas Academy of Family Physicians

Health Reform to Address Primary Care Practice Issues

- New paradigm of health care focused on wellness and disease prevention
- Systems of practice that emphasize team care
- Systems of practice that embrace all forms of communication between the patient and their health care team
- Payment reforms that incentivize the best quality patient outcomes

Meetings of all the Organizations in Kansas that Represent Primary Care Physicians

- Kansas Primary Care Physician's Summit on the Patient Centered Medical Home
  - Kansas Academy of Family Physicians
  - Kansas Chapter of the American Academy of Pediatrics
  - Kansas Chapter of the American College of Physicians
  - Kansas Association of Osteopathic Medicine
  - Kansas Medical Society

Patient Centered Medical Homes in Kansas

- A Patient Centered Medical Home (PCMH) is simply a more effective and efficient model of health care delivery. A growing body of research shows that this new model produces better care and control rising health care costs.

In a Patient Centered Medical Home in Kansas:

- Patients have a **relationship** with a physician or other personal care provider in a physician-directed team.
- A practice-based care team takes collective responsibility for the patient's **ongoing care**.
- The physician-directed **Care Team** is responsible for providing for the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals.
- Patients can expect care that is **coordinated** across care settings and disciplines.
- **Quality** is measured and improved as part of daily work flow.
- Patients experience **enhanced access** and communication.
- The practice uses **electronic health records**, registries, and other **clinical support systems**.

Crossing the Quality Chasm

- Healthcare Redesign Requires
  - Adopting new ways of delivering care
  - Making effective use of information technology
  - Managing clinical knowledge and skills of the workforce
  - Developing effective teams and coordinating/integrating care across patient conditions, services, and settings
  - Improving how quality is measured
  - Adopting payment methods that create incentives and reward good quality

Transforming to a PCMH?

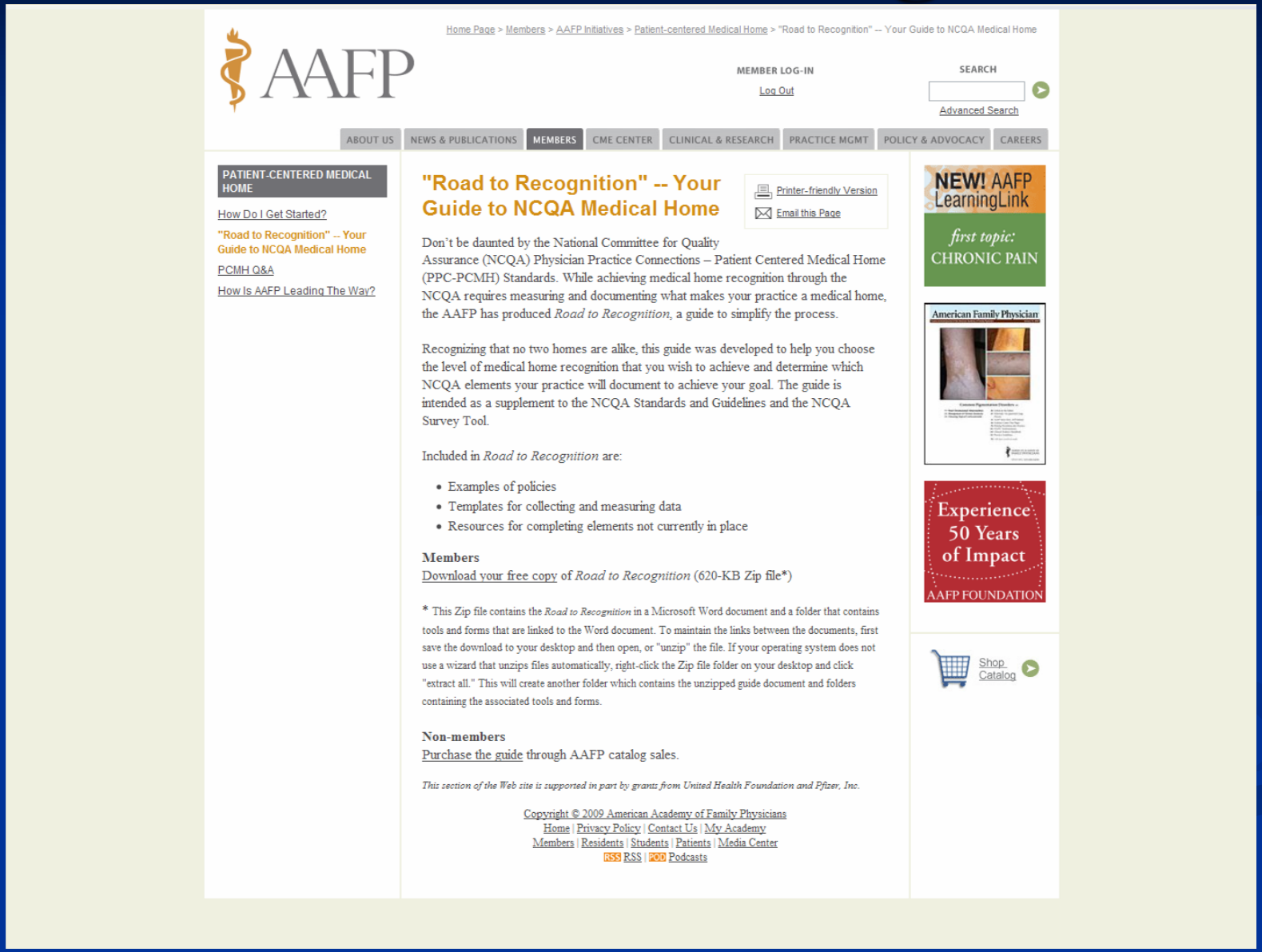
- Primary Care practices will need to go through a transformation process
- Potential for increase costs and decreased access during the transformation
  - Very important to minimize this effect
- The gain is a new paradigm of care that is much more efficient and has better outcomes resulting in containment of the exponential rise in health care costs.

Information on Transformation

- **Sites for basic information on the PCMH**
  - American Academy of Family Physic
    - http://www.aafp.org/online/en
      quide.html
  - TransforMED (look for their data in
    - http://www.transformed.com/
  - Patient-Centered Primary Care Collab
    - http://www.pcpcc.net/
  - NCQA Recognition
    - http://www.ncqa.org/tabid/629

Surf the Web!!!

AAFP "Road to Recognition"



Home Page > Members > AAFP Initiatives > Patient-centered Medical Home > "Road to Recognition" -- Your Guide to NCQA Medical Home

AAFP

MEMBER LOG-IN
Log Out

SEARCH
Advanced Search

ABOUT US | NEWS & PUBLICATIONS | MEMBERS | CME CENTER | CLINICAL & RESEARCH | PRACTICE MGMT | POLICY & ADVOCACY | CAREERS

PATIENT-CENTERED MEDICAL HOME

How Do I Get Started?
"Road to Recognition" -- Your Guide to NCQA Medical Home
PCMH Q&A
How Is AAFP Leading The Way?

"Road to Recognition" -- Your Guide to NCQA Medical Home

Printer-friendly Version
Email this Page

Don't be daunted by the National Committee for Quality Assurance (NCQA) Physician Practice Connections – Patient Centered Medical Home (PPC-PCMH) Standards. While achieving medical home recognition through the NCQA requires measuring and documenting what makes your practice a medical home, the AAFP has produced *Road to Recognition*, a guide to simplify the process.

Recognizing that no two homes are alike, this guide was developed to help you choose the level of medical home recognition that you wish to achieve and determine which NCQA elements your practice will document to achieve your goal. The guide is intended as a supplement to the NCQA Standards and Guidelines and the NCQA Survey Tool.

Included in *Road to Recognition* are:

- Examples of policies
- Templates for collecting and measuring data
- Resources for completing elements not currently in place

Members
Download your free copy of *Road to Recognition* (620-KB Zip file*)

* This Zip file contains the *Road to Recognition* in a Microsoft Word document and a folder that contains tools and forms that are linked to the Word document. To maintain the links between the documents, first save the download to your desktop and then open, or "unzip" the file. If your operating system does not use a wizard that unzips files automatically, right-click the Zip file folder on your desktop and click "extract all." This will create another folder which contains the unzipped guide document and folders containing the associated tools and forms.

Non-members
Purchase the guide through AAFP catalog sales.

This section of the Web site is supported in part by grants from United Health Foundation and Pfizer, Inc.

http://www.aafp.org/online/en/home/membership/initiatives/pcmh/ncqaquide.html

TransforMED℠
Patient Centered Medical Home

Access to Care and Information
- Health care for all
- Same-day appointments
- After-hours access coverage
- Lab results highly accessible
- Online patient services
- e-Visits
- Group visits

Practice Management
- Disciplined financial management
- Cost-Benefit decision-making
- Revenue enhancement
- Optimized coding & billing
- Personnel/HR management
- Facilities management
- Optimized office design/redesign
- Change management

Practice Services
- Comprehensive care for both acute & chronic conditions
- Prevention screening and services
- Surgical procedures
- Ancillary therapeutic and support services
- Ancillary diagnostic services

Health Information Technology
- Electronic medical record
- Electronic orders and reporting
- Electronic prescribing
- Evidence-based decision support
- Population management registry
- Practice Web site
- Patient portal

A continuous relationship with a personal physician coordinating care for both wellness and illness

- Mindful clinician-patient communication: *trust, respect, shared decision-making*
- Patient engagement
- Provider/patient partnership
- Culturally sensitive care
- Continuous relationship
- Whole person care

Care Management
- Population management
- Wellness promotion
- Disease prevention
- Chronic disease management
- Care coordination
- Patient engagement and education
- Leverages automated technologies

Quality and Safety
- Evidence-based best practices
- Medication management
- Patient satisfaction feedback
- Clinical outcomes analysis
- Quality improvement
- Risk management
- Regulatory compliance

Continuity of Care Services
- Community-based resources
- Collaborative relationships
  - Hospital care
  - Behavioral health care
  - Maternity care
  - Specialist care
  - Pharmacy
  - Physical Therapy
  - Case Management

Practice-Based Care Team
- Provider leadership
- Shared mission and vision
- Effective communication
- Task designation by skill set
- Nurse Practitioner / Physician Assistant
- Patient participation
- Family involvement options

Find out more at **www.TransforMED.com**

version 2.3.1 - 12/2008

Search

Sections

- About the PCPCC
- The Patient Centered Medical Home
- Collaborative Centers
- Events
- Consumers & Patients
- Health Reform
- Pilot Projects
- Purchaser Guide
- Calendar
- National Weekly Call
- Press Releases
- Contact Us
- January 28th Web Seminar Registration
- Joining the PCPCC

Member Login

Login/Register

The Patient Centered Primary Care Collaborative is a coalition of major employers, consumer groups, patient quality organizations, health plans, labor unions, hospitals, physicians and many others who have joined together to develop and advance the patient centered medical home. The Collaborative has well over 300 members.

The Collaborative believes that, if implemented, the patient centered medical home will improve the health of patients and the viability of the health care delivery system. In order to accomplish our goal, employers, consumers, patients, physicians and payers have agreed that it is essential to support a better model of compensating physicians.

Patient-Centered Primary Care Collaborative

PCPCC News and Updates

Latest News | Press Releases | Newsletter | Videos | Calendar

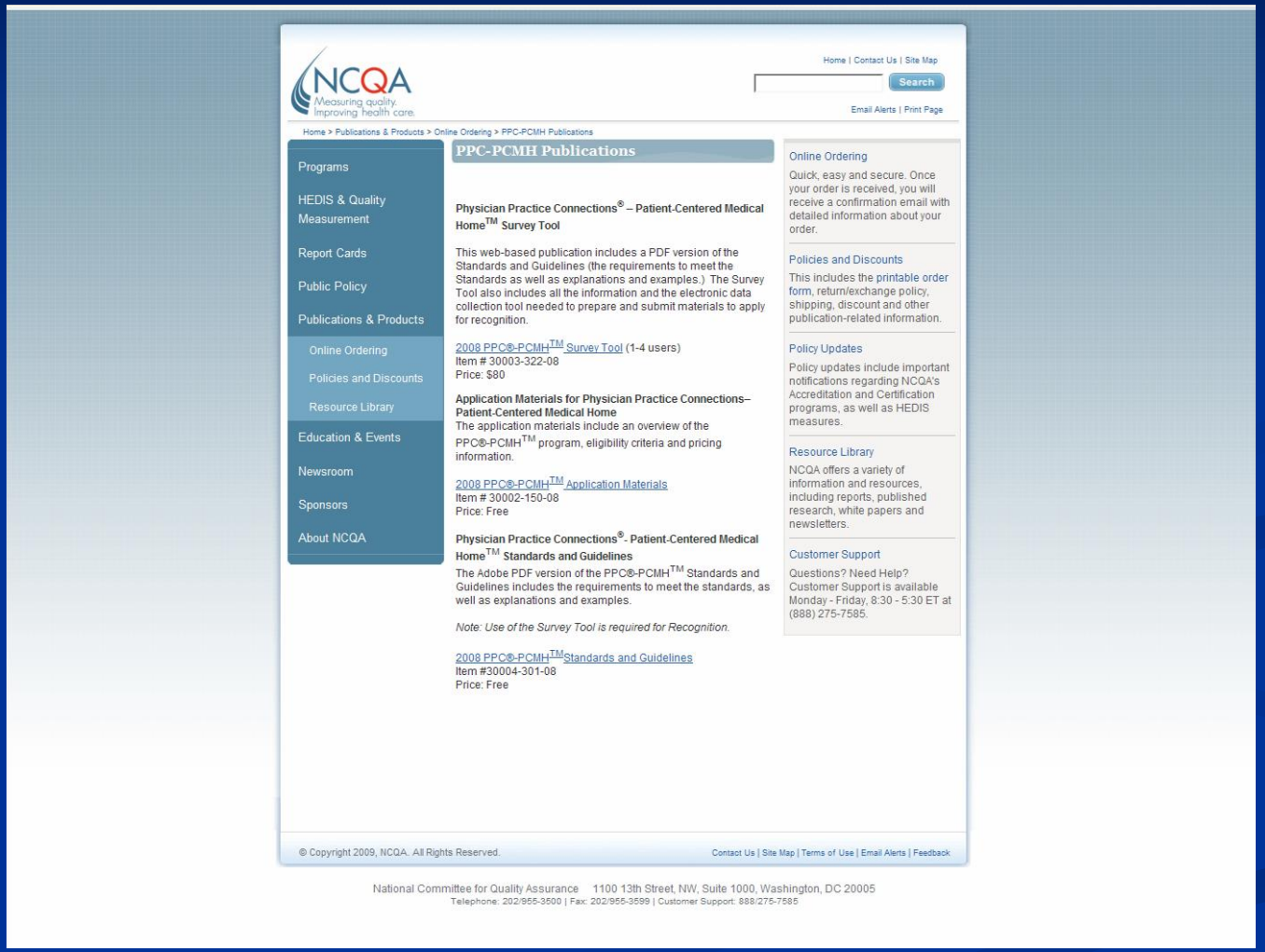
- "The Purchasers Guide to the Medical Home" - PCPCC Web Seminar Registration
- Guidelines for Patient Centered Medical Home (PCMH) Demonstration Projects
- Rhode Island sample legal letter used for work developing the multi-payer PCMH pilots
- American Medical Association Adopts Principles for Patient-Centered Medical Home
- October 17th Annual Summit Video
- Incentivizing the Patient-Doctor Relationship though Medical Home Model - Newt Gingrich
- Voters Want the Patient-Centered Primary Care to be a Key Component in Fixing Health Care
- PCPCC Pilot Projects
- October 17th 2008 - Annual Summit Agenda
- ATTENTION: REGISTRATION FOR OCTOBER 17th SUMMIT IS NOW CLOSED

more

Collaborative Center Updates

CPPI | CMD | CBRI | CeHIA | Press Releases

NCQA



http://www.ncqa.org/tabid/629/Default.aspx

NCQA Standards and Guidelines

Standards and Guidelines for Physician Practice Connections®— Patient-Centered Medical Home (PPC-PCMH™)

PCMH-PPC Proposed Content and Scoring

Standard 1: Access and Communication	Pts
A. Has written standards for patient access and patient communication**	4
B. Uses data to show it meets its standards for patient access and communication**	5
	9

Standard 2: Patient Tracking and Registry Functions	Pts
A. **Uses data system for basic patient information (mostly non-clinical data)**	2
B. **Has clinical data system with clinical data in searchable data fields**	3
C. **Uses the clinical data system**	3
D. Uses paper or electronic-based charting tools to organize clinical information**	6
E. Uses data to identify important diagnoses and conditions in practice**	4
F. **Generates lists of patients and reminds patients and clinicians of services needed (population management)**	3
	21

Standard 3: Care Management	Pts
A. Adopts and implements evidence-based guidelines for three conditions **	3
B. **Generates reminders about preventive services for clinicians**	4
C. **Uses non-physician staff to manage patient care**	
D. **Conducts care management, including care plans, assessing progress, addressing barriers**	3 5
E. **Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities**	5
	20

Standard 4: Patient Self-Management Support	Pts
A. **Assesses language preference and other communication barriers**	2 4
B. Actively supports patient self-management**	
	6

Standard 5: Electronic Prescribing	Pts
A. **Uses electronic system to write prescriptions**	3
B. **Has electronic prescription writer with safety checks**	3
C. **Has electronic prescription writer with cost checks**	2
	8

Standard 6: Test Tracking	Pts
A. Tracks tests and identifies abnormal results systematically**	7
B. **Uses electronic systems to order and retrieve tests and flag duplicate tests**	6
	13

Standard 7: Referral Tracking	PT
A. Tracks referrals using paper-based or electronic system**	4
	4

Standard 8: Performance Reporting and Improvement	Pts
A. Measures clinical and/or service performance by physician or across the practice**	3
B. **Survey of patients' care experience**	
C. Reports performance across the practice or by physician **	3
D. **Sets goals and takes action to improve performance**	3
E. **Produces reports using standardized measures**	
F. **Transmits reports with standardized measures electronically to external entities**	3 2 1
	15

Standard 9: Advanced Electronic Communications	Pts
A. **Availability of Interactive Website**	1
B. **Electronic Patient Identification**	2
C. **Electronic Care Management Support**	1
	4

** Priority Elements

Physician Organizations in Kansas to Contact for More Information

- Representing current and future primary care physicians who serve on the front lines of medicine providing care to the citizens of Kansas.
  - Kansas Academy of Family Physicians, Carolyn Gaughan, Executive Director, kafp@kafponline.org
  - Kansas Chapter American Academy of Pediatrics, Chris Steege, Executive Director, kansasAAP@aol.com
  - Kansas Association of Osteopathic Medicine, Bob Williams, Executive Director, kansasdo@aol.com
  - Kansas Chapter American College of Physicians, Garold Minns, MD, Governor, gminns@kumc.edu
  - Kansas Medical Society, Jerry Slaughter, Executive Director, jslaughter@kmsonline.org

"Patient Centeredness" would require transformation in many practices

- All the main features of PCMH require increased modes of communication in the home
- EHR is central to all the significant transformative pieces of a medical home
- Current expensive medical records systems are out of reach of many physicians in smaller practices
- Resources for transformation need to be provided to smaller practices
  - Larger and network-affiliated practices are likely to be the most ready to meet the standards for a patient-centered medical home, but providing targeted resources could help smaller, non-affiliated practices adopt necessary measures and improve quality of care. [Friedberg; JGIM; 12-3-08]

Standardized EHR Core

- One of the most important pieces in the new paradigm of the medical home is a standardized medical record core throughout the system

Medical care is t
on individual sy
central sta

Health Information Technology is KEY

- Patient access to health information
  - Personal
  - Health care topics
- Access to PCMH
  - Appointment systems
  - Management of chronic disease
  - Disease prevention
- Public Health
- Many Other Functions

It Is Happening?

- Health Reform in America is going to happen with the new administration
- Health reform is a top priority
- The discussion has already begun
- Plans are already being made for transformation

Health IT, Primary Care in Stimulus Bill

- $500 million in additional funding for health care workforce programs, including primary care training grants
- $1.1 billion for comparative clinical effectiveness research
- Maximum amount of $44,000 per physician during a five-year period to adopt HIT in their practice
- Providers in rural health professional shortage areas, or HPSAs, will have their incentive payments increased by 25 percent

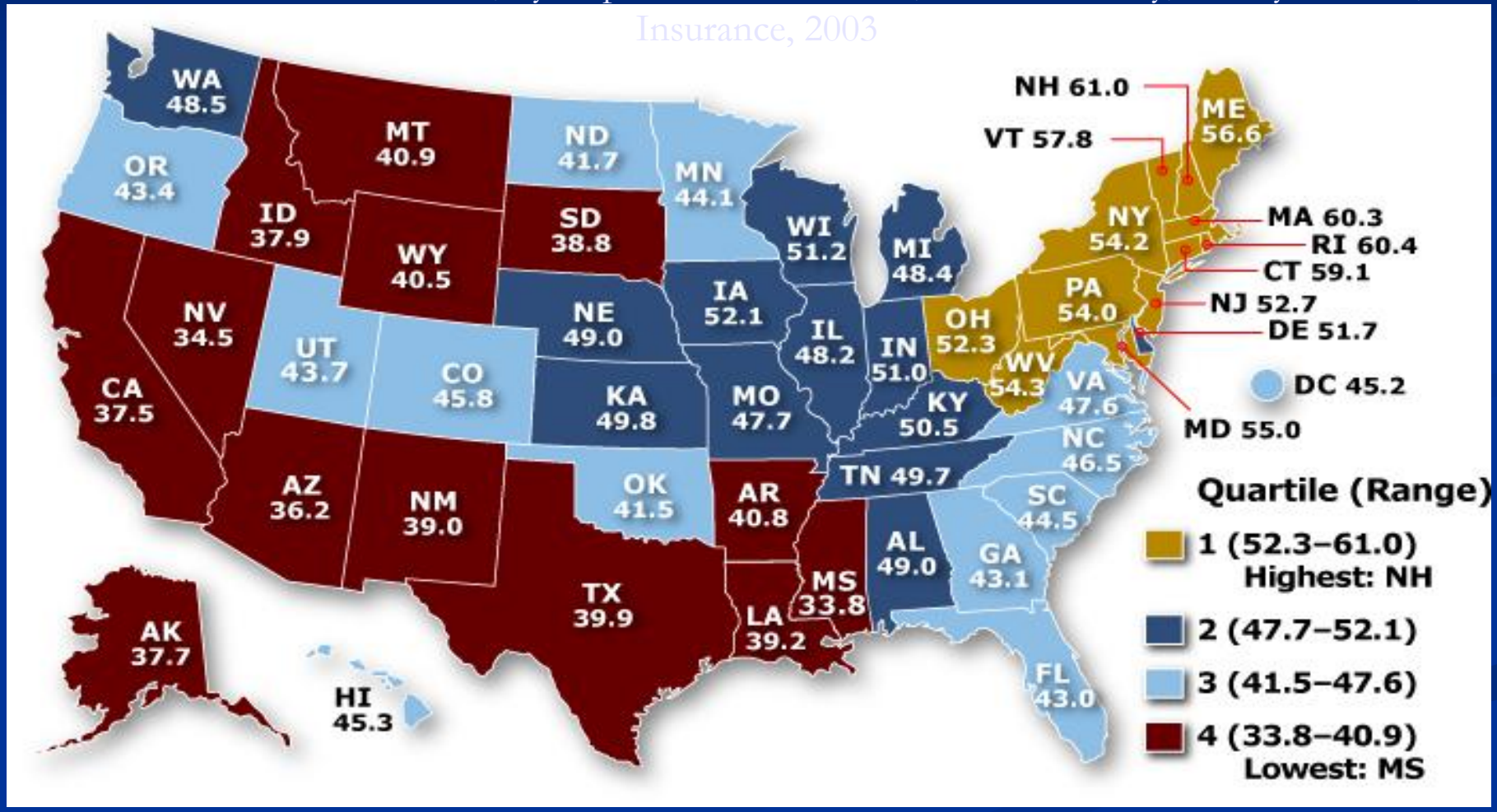
AAFP News - Health IT, Primary Care Come Out Ahead in Massive Stimulus Bill
http://www.aafp.org/online/en/home/publications/news/news-now/government-medicine/20090213stimulus-passes.html, accessed 2-19-09

Getting Value for Money: Health System Transformation

- Transparency; public information on clinical quality, patient-centered care, and efficiency by provider; insurance premiums, medical outlays, and provider payment rates
- Payment systems that reward quality and efficiency; transition to population and care episode payment system
- Patient-centered medical home; Integrated delivery systems and accountable physician group practices
- Adoption of health information technology; creation of state-based health insurance exchange
- National Institute of Clinical Excellence; invest in comparative cost-effectiveness research; evidence-based decision-making
- Investment in high performance primary care workforce
- Health services research and technical assistance to spread best practices
- Public-private collaboration; national aims; uniform policies; simplification; purchasing power

Percentage Whose Care Met the Definition of a Medical Home: Children and Adolescents Ages 0–17 by State, 2003

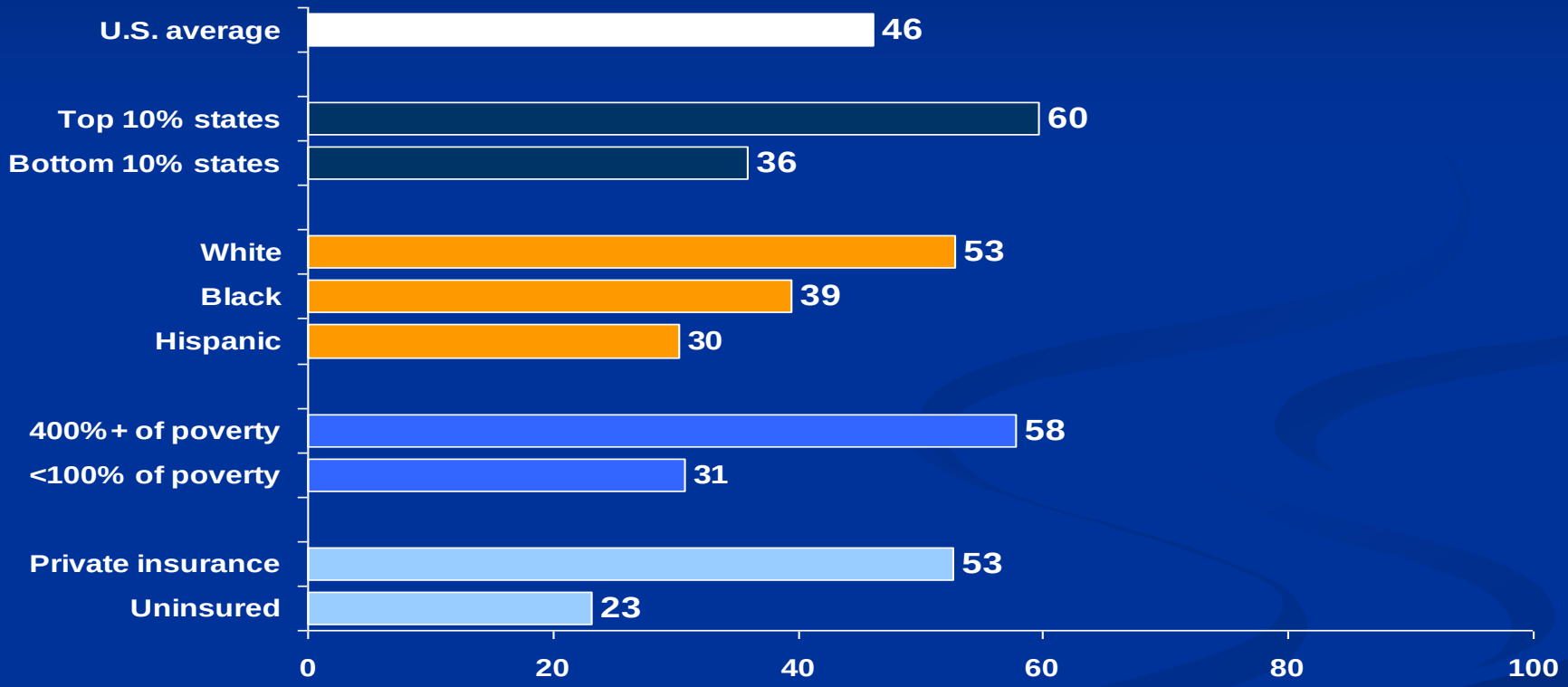
Children with a Medical Home, by Top and Bottom States, Race/Ethnicity, Family Income, and Insurance, 2003



Data: National Survey of Children's Health (Child and Adolescent Health Measurement Initiative 2005).

Children with a Medical Home, by Top and Bottom States, Race/Ethnicity, Family Income, and Insurance, 2003

Percent of children who have a personal doctor or nurse and receive care that is accessible, comprehensive, culturally sensitive, and coordinated*



Note: Indicator was not updated due to lack of data. Baseline figures are presented.
* Child had 1+ preventive visit in past year; access to specialty care; personal doctor/nurse who usually/always spent enough time and communicated clearly, provided telephone advice or urgent care and followed up after the child's specialty care visits.
Data: 2003 National Survey of Children's Health (HRSA 2005; retrieved from Data Resource Center for Child and Adolescent Health database at http://www.nschdata.org).

Operationalizing the Medical Home Concept

Goal: Create a medical home model(s) for Kansas

- Internal Working Group
- All Stakeholders Group
  - Principles subgroup
  - Marketing/Messaging subgroup
  - Pilot Projects subgroup
- Payment reforms and incentives built into pilots

REVIEW:
Medical Home-Key Elements

- Team approach to care
- Registries for the top few diagnoses
- Active care coordination
- Prospective data collection
- Partnership with community resources
- Advanced patient education and self management support

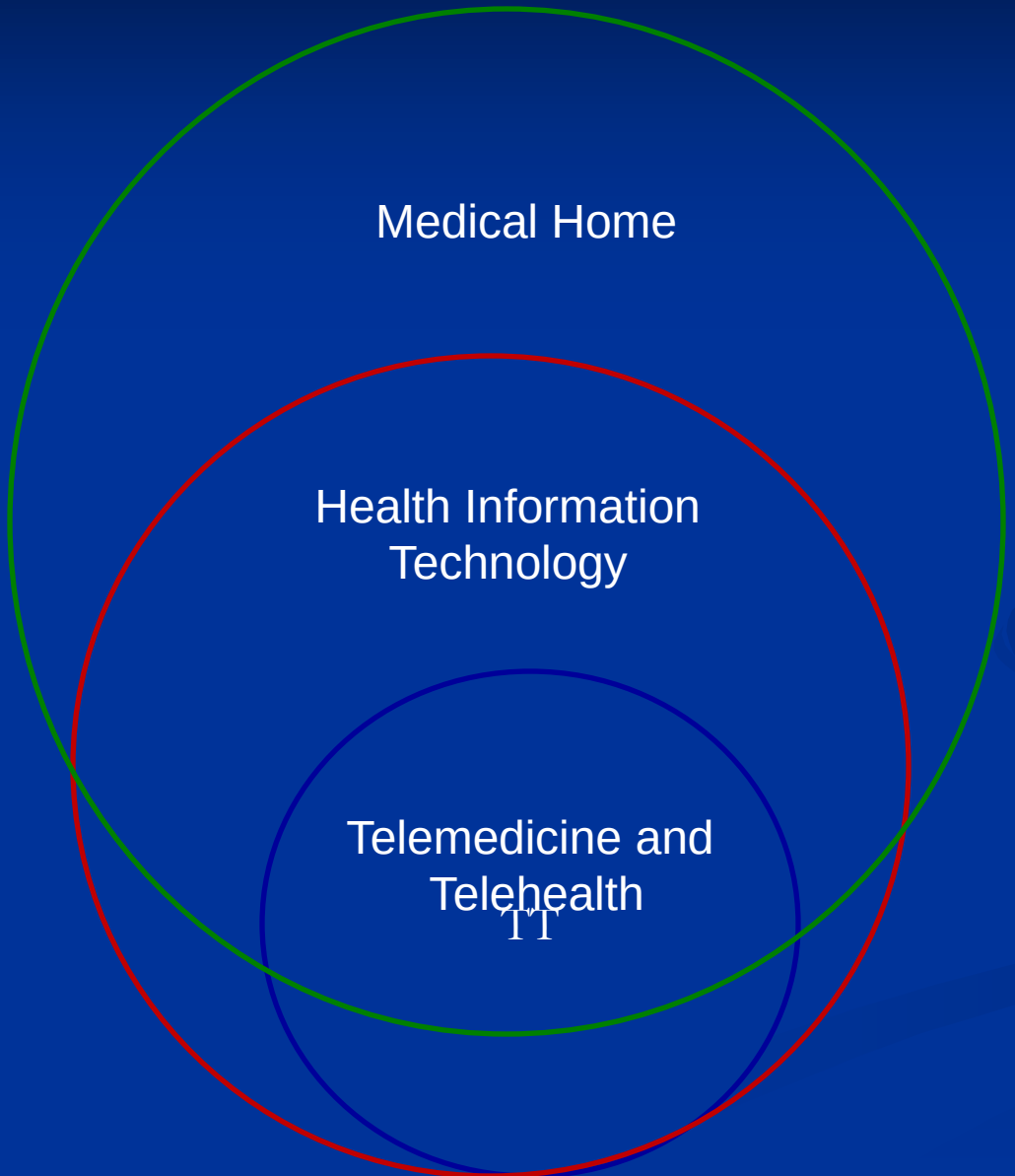
How Will I Know One When I See One?

- Commitment to care for the whole person
- Demonstrated use of tools and systems including registries and eventually EHR
- New NCQA medical home recognition program (PPC)
- Patient satisfaction and health outcomes

National Academy for State Health Policy Medical Home Project

- July 2008 NASHP in partnership with PCPCC selected 8 states for advancement of the Medical Home concept
- Kansas was selected as one of the participants
- Others were - CO, ID, LA, MN, NH, NC, OK, OR, RI, WA

Goals & Dollars



Goals:

- **Improve health**
- **Improve coordination of care**
- **Reduce duplication of services**
- **Save system dollars**

Dollars:

- **Provider $ stretched**
- **State $ non-existent**
- **Federal $ through stimulus package**

HOW DO YOU WANT THE MONEY SPENT?